Mother's Name or Imprint: Baby's Name or Imprint:

MODULE 3 - NEWBORN DELIVERY

(COMPLETE A SEPARATE NEWBORN DELIVERY MODULE FOR EACH LIVE BIRTH.
COMPLETE A FETAL DEATH MODULE 3 WORKSHEET FOR OTHER THAN LIVE BIRTH OUTCOMES.)

1. DATE OF DELIVERY/BIRTH
____ / ____ / ____
Mo. Day Yr.

2. TIME (HOUR)
____ ☐AM ☐PM

3. DELIVERY OUTCOME (Check one)
01 ☐ Live Birth
02 ☐ Fetal Death Before Labor (Antepartum Fetal Death)
03 ☐ Fetal Death During Labor (Intrapartum Fetal Death)
04 ☐ Second Trimester Termination
05 ☐ Fetal Death During Delivery (Intrapartum Fetal Death)

4. METHOD OF DELIVER (Check all that apply)
01 ☐ Outlet Forceps
02 ☐ Low Forceps
03 ☐ Mid Forceps
04 ☐ Other Forceps
05 ☐ Vacuum
06 ☐ Spontaneous/Assisted Breech
07 ☐ Version and Extraction
08 ☐ Breech Extraction
09 ☐ Vaginal
10 ☐ C-Section, Failed Trial Labor VBAC
11 ☐ C-Section, No Trial Labor
12 ☐
13 ☐ Failed VBAC

5. CHILD'S PLURALITY
01 ☐ Single
02 ☐ Twin
03 ☐ Triplet
04 ☐ Quad
05 ☐ Higher
Specify: ____

6. IF NOT SINGLE BIRTH, THIS CHILD BORN
(1=1st, 2=2nd, 3=3rd, 4=4th, etc.)

IF MULTIPLE BIRTH
7. ____ WERE LIVE BIRTHS
8. ____ WERE FETAL DEATHS

QUESTIONS 9 THROUGH 13 REFER TO ONLY OTHER LIVE BIRTHS OR TERMINATIONS RESULTING FROM THIS PREGNANCY, DELIVERED BEFORE THIS BABY. COMPLETE ONLY IF THE BIRTH ORDER IS GREATER THAN ONE.

9. NUMBER OF LIVE BIRTHS LIVING

10. NUMBER OF LIVE BIRTHS NOW DEAD

11. DATE OF LAST LIVE BIRTH
____ / ____

12. NUMBER OF PREGNANCY LOSSES

13. DATE OF LAST PREGNANCY LOSS
____ / ____

14. INFANT'S SEX
01 ☐ Male 02 ☐ Female 03 ☐ Unknown

15. APGAR SCORES (LIVE BIRTHS ONLY)
1 Min: ____ 5 Min: ____

16. WEIGHT AT DELIVERY/BIRTH
____ Grams OR ____ Lbs. ____ Oz.

17. CLINICAL ESTIMATE OF GESTATION
____ Weeks

18. NAME OF PRIMARY ATTENDANT (Print)
____
(First) (MI) (Last)

19. PLACE OF DELIVERY
01 ☐ Hospital
02 ☐ Freestanding Birthing Center
03 ☐ Clinic/Doctor's Office
04 ☐ Residence
05 ☐ Other, Specify: ____

20. PRIMARY ATTENDANT TYPE (Check one)
01 ☐ MD
02 ☐ DO
03 ☐ CNM
04 ☐ Other Midwife
05 ☐ Other, Specify: ____

21. FACILITY NAME (If delivery did not take place at this facility):

22. CONGENITAL ANOMALIES OF CHILD (Check all that apply)

CENTRAL NERVOUS SYSTEM
01 ☐ Anencephalus
02 ☐ Spina Bifida/Meningocele
03 ☐ Hydrocephalus
04 ☐ Microcephalus
05 ☐ Other Central Nervous System Anomalies, Specify: ____

HEART
06 ☐ Heart Malformations
07 ☐ Other Circulatory/Respiratory Anomalies, Specify: ____

GASTROINTESTINAL
08 ☐ Rectal Atresia/Stenosis
09 ☐ Tracheo-Esophageal Fistula/ Esophageal Atresia
10 ☐ Omphalocele/Gastroschisis
11 ☐ Other Gastrointestinal Anomalies, Specify: ____

UROGENITAL
12 ☐ Malformed Genitalia
13 ☐ Renal Agenesis
14 ☐ Other Urogenital Anomalies, Specify: ____

MUSCULOSKELETAL
15 ☐ Cleft Lip/Palate
16 ☐ Polydactyly/Syndactyly/Adactyly
17 ☐ Club Foot
18 ☐ Diaphragmatic Hernia
19 ☐ Other Musculoskeletal/ Integumental Anomalies, Specify: ____

CHROMOSOMAL
20 ☐ Down Syndrome
21 ☐ Other Chromosomal Anomalies, Specify: ____

NOT COVERED ELSEWHERE
22 ☐ Other, Specify: ____
23 ☐ Unknown
00 ☐ None

(*N.J.S.A. 26:8-40.20 ET SEQ., SPECIFICALLY 26:8-40.26 REQUIRES BIRTH DEFECTS AND OTHER SPECIFIED CONDITIONS TO BE REPORTED TO THE NEW JERSEY BIRTH DEFECTS REGISTRY.)

23. ABNORMAL CONDITIONS OF THE NEWBORN (Check all that apply)

DELIVERY ROOM RESUSCITATION
01 ☐ Pharmacologic
02 ☐ Intubation
03 ☐ Oxygen
04 ☐ Oxygen + Pos. Pressure
05 ☐ Cord Ph Obtained

CONDITIONS OCCURRING PRIOR TO THE ISSUANCE OF THE BIRTH CERTIFICATE
06 ☐ Anemia (Hct <39/Hgb<13
07 ☐ Birth Injury
08 ☐ Fetal Alcohol Syndrome
09 ☐ Hyaline Membrane Dis./RDS
10 ☐ Meconium Aspiration Syndrome
11 ☐ Assisted Ventilation <30 Min.
12 ☐ Assisted ventilation >30 Min.
13 ☐ Seizures
14 ☐ Other, Specify: ____
15 ☐ Unknown
00 ☐ None

24. INFANT'S BLOOD TYPE: ☐A ☐B ☐O ☐AB RH: ☐Positive ☐Negative

Name of Individual Completing This Module	Signature	Date